DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4724 (05/01)

STATE OF WISCONSIN
ss. 255.075, Wis. Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP)
Breast Cancer Diagnostic and Follow Up Report (DRF)

Information and Instruction on reverse side

PERSONAL INFORMATION

1. Last Name	2. First Name	3. Middle Initial
4. Maiden Name	5. Date of birth (mm/dd/yyyy)	

6. Social Security Number (Optional) or Client Identification Number

BREAST DIAGNOSTIC PROCEDURES

7. **ADDITIONAL MAMMOGRAM VIEWS** ☐ Yes ☐ No ☐ Refused by client

☐ Not done, give reason_____

Date performed (mm/dd/yyyy)_____

8. Provider / Clinic_____

9. City where performed_____

10. Check all that apply

RESULT

Date of Result(s) (mm/dd/yyyy)_____

☐ Negative finding
☐ Benign finding
☐ Probably Benign - Short Term Follow up
☐ Suspicious Abnormality - Consider Biopsy
☐ Highly suggestive of malignancy
☐ Assessment incompleted

19. **ULTRASOUND** ☐ Yes ☐ No ☐ Refused by client

☐ Not done, give reason_____

Date performed (mm/dd/yyyy)_____

20. Provider / Clinic_____

21. City where performed_____

22. Check all that apply

RESULT

Date of Result(s) (mm/dd/yyyy)_____

☐ Normal / No abnormality
☐ Cystic mass
☐ Suspicious for malignancy
☐ Other benign abnormality

11. **CONSULTANT'S BREAST EXAM** ☐ Yes ☐ No ☐ Refused by client

☐ Not done, give reason_____

Date performed (mm/dd/yyyy)_____

12. Provider / Clinic_____

13. City where performed_____

14. Check all that apply

RESULT

Date of Result(s) (mm/dd/yyyy)_____

☐ Normal Exam
☐ Benign finding (Fibrocystic changes)
☐ Discrete palpable mass
☐ Nipple or Areolar scaliness
☐ Skin dimpling
☐ Bloody or Serous Nipple discharge

23. **SURGICAL CONSULTATION** ☐ Yes ☐ No ☐ Refused by client

☐ Not done, give reason_____

Date performed (mm/dd/yyyy)_____

24. Provider / Clinic_____

25. City where performed_____

26. Check all that apply

RESULT

Date of Result(s) (mm/dd/yyyy)_____

☐ No intervention, routine follow up
☐ Short term follow up
☐ Biopsy / FNA recommended

15. **FINE NEEDLE ASPIRATION** ☐ Yes ☐ No ☐ Refused by client

☐ Not done, give reason_____

Date performed (mm/dd/yyyy)_____

16. Provider / Clinic_____

17. City where performed_____

18. Check all that apply

RESULT

Date of Result(s) (mm/dd/yyyy)_____

☐ No fluid or tissue obtained
☐ Not suspicious for cancer
☐ Suspicious for cancer

27. **BIOPSY** ☐ Yes ☐ No ☐ Refused by client

☐ Not done, give reason_____

Date performed (mm/dd/yyyy)_____

28. Provider / Clinic_____

29. City where performed_____

30. Check all that apply

RESULT

Date of Result(s) (mm/dd/yyyy)_____

☐ Normal breast tissue
☐ Other benign changes
☐ Hyperplasia
☐ Carcinoma in Situ*
☐ Invasive breast cancer

31. **Recommendation -** Must complete Status Of Final Diagnosis Date performed (mm/dd/yyyy)_____

☐ Follow routine screening schedule_____months. ☐ Short Term Follow up_____months_____procedure

☐ Repeat Diagnostic Mammogram ☐ Ultrasound ☐ Consultant's Breast Exam ☐ Surgical Consultation ☐ Fine Needle Aspiration ☐ Biopsy

☐ Other (**MRI, etc**)* *__Not paid by WWWP__

32. **Status Of Final Diagnosis** - Check appropriate box

☐ Complete ☐ Pending ☐ Client Deceased ☐ Lost to Follow up ☐ Refused work-up

33. **Final Diagnosis** ☐ Breast cancer not diagnosed ☐ Carcinoma in Situ (CIS)* ☐ Ductal Carcinoma in Situ (DCIS)*

☐ Lobular Carcinoma on Situ (LCIS)* *Complete Treatment Status section

34. **Invasive breast cancer (complete stage and tumor size**)

Tumor Stage (AJCC) ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Unstaged ☐ Unknown

Tumor size _____cm. **Reporting stages should be in AJCC categories, not in summary**

35. **Treatment Status** ☐ Treatment started (mm/dd/yyyy) _____ ☐ Refused by client ☐ Lost to follow up on (mm/dd/yyyy) _____

☐ Not indicated / not needed ☐ Other problems _____ ☐ Client deceased (mm/dd/yyyy) _____

Return completed top copy of form only to: WWWP, P.O. Box 6645, Madison, WI 53716-0645

White (Top) Copy - WWWP **Yellow (2nd) Copy - Provider** **Pink (3rd)Copy - Local Coordinating Agency**

INSTRUCTIONS FOR WISCONSIN WELL WOMAN PROGRAM (WWWP)

Breast Cancer Diagnostic and Follow Up Report Form (DRF)

The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

PERSONAL INFORMATION

1. Print client's Last Name.
2. Print client's First Name.
3. Print client's Middle Initial.
4. Print client's Maiden Name, if applicable.
5. Indicate client's Date of Birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate client's Social Security Number (SSN) or Client Identification Number (CIN). The SSN is optional and will be used to determine the client's eligibility for services and to identify her status with other healthcare programs. The Local Coordinating Agency assigns the CIN.

BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAM VIEWS

7. Indicate if additional views were performed. If a Diagnostic Mammogram was not performed, please indicate why. Indicate the Date the Diagnostic Mammogram was performed. Use numbers for month, day and year, i.e. 01/15/2000.
8. Indicate the name of the Provider or Clinic where the Diagnostic Mammogram was performed.
9. Indicate the City where the provider/clinic who performed the Diagnostic Mammogram is located.
10. Indicate the Date the Results of the Diagnostic Mammogram were determined. Use numbers for month, day and year, i.e. 01/15/2000. Then check the appropriate box to indicate the Results of the Diagnostic Mammogram. CONSULTANT'S BREAST EXAM
11. Indicate if Consultant's Breast Exam was performed. Indicate the Date the Consultant's Breast Exam was performed. Use numbers for month, day and year, i.e. 01/15/2000.
12. Indicate the Name of the Provider or Clinic where the Consultant's Breast Exam was performed.
13. Indicate the City where the provider/clinic who performed the Consultant's Breast Exam is located.
14. Indicate the Date the Results of the Consultant's Breast Exam were determined. Use numbers for month, day and year, i.e. 01/15/2000. Then check the appropriate box to indicate the Results of the Consultant's Breast Exam. If a Consultant's Breast Exam was not performed, please indicate why.

FINE NEEDLE ASPIRATION

15. Indicate if the Fine Needle Aspiration was performed. **If a** Fine Needle Aspiration was not performed, please indicate why. Indicate the Date Use numbers for month, day and year, i.e. 01/15/2000.
16. Indicate the Name of the Provider or Clinic where the Fine Needle Aspiration was performed.
17. Indicate the City where the provider/clinic who performed the Surgical Consultation is located.
18. Indicate the Date the Results of the Fine Needle Aspiration were determined. Use numbers for month, day and year, i.e. 01/15/2000. Then check the appropriate box to indicate the Results of the Fine Needle Aspiration.

ULTRASOUND

19. Indicate if Ultrasound was performed. If an Ultrasound was not performed, please indicate why. Indicate the Date the Ultrasound was performed. Use numbers for month, day and year, i.e. 01/15/2000.
20. Indicate the Name of the Provider or Clinic where the Ultrasound was performed.
21. Indicate the City where the provider/clinic who performed the Ultrasound is located.
22. Indicate the Date the Results of the Ultrasound were determined. Use numbers for month, day and year, i.e. 01/15/2000. Then check the appropriate box to indicate the Results of the ultrasound.

SURGICAL CONSULTATION

23. Indicate if a Surgical Consultation was performed. If a Surgical Consultation was not performed, please indicate why. Indicate the Date the Surgical Consultation was performed. Use numbers for month, day and year, i.e. 01/15/2000.
24. Indicate the Name of the Provider or Clinic where the Surgical Consultation was performed.
25. Indicate the City where the provider/clinic who performed the Surgical Consultation is located.
26. Indicate the Date the Results of the Surgical Consultation were determined. Use numbers for month, day and year, i.e. 01/15/2000. Then check the appropriate box to indicate the Results of the Surgical Consultation.

BIOPSY

27. Indicate if a Biopsy was performed. If a Biopsy was not performed, please indicate why. Indicate the Date the Biopsy was performed. Use numbers for month, day and year, i.e. 01/15/2000.
28. Indicate the Name of the Provider or Clinic where the Biopsy was performed.
29. Indicate the City where the provider/clinic who performed the Surgical Consultation is located.
30. Indicate the Date the Results of the Biopsy were determined. Use numbers for month, day and year, i.e. 01/15/2000. Check the appropriate box to indicate the Results of the Biopsy.

STATUS OF FINAL DIAGNOSIS

31. Check appropriate box to indicate recommendations. Use numbers for month, day and year, i.e. 01/15/2000. The Status of Final Diagnosis section must be completed.
32. Check the appropriate box to indicate the Status of this Final Diagnostic Report and indicate the Date that this Final Diagnostic Report was completed. Use numbers for month, day and year, i.e. 01/15/2000.
33. Check the appropriate box to indicate the Final Diagnosis.
34. If Final Diagnosis is Invasive Breast Cancer check the appropriate box to indicate the Stage and size of the Tumor. NOTE: The reporting stages should be in AJCC categories, not summary stages.
35. Check the appropriate box to indicate Treatment Status and indicate the date treatment started. Use numbers for month, day and year, i.e. 01/15/2000.

Return completed form, White(Top) Copy Only to:

WWWP
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Madison, WI 53716-0645